DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445509	B. WING			12/02/2020	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF OLD HICKORY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1250 ROBINSON ROAD OLD HICKORY, TN 37138				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC' PREFIX (EACH CORRECTIVE ACTION SHOULD FOR CROSS-REFERENCED TO THE APPRINT DEFICIENCY)		BE .	(X5) COMPLETION DATE
F 000	A COVID-19 Focus was conducted by SThe facility was fou CFR §483.80 infect has implemented the Disease Control and recommended practice COVID-19. Total certain the control of the control	sed Infection Control Survey State Agency on 12/2/ 2020. Ind to be in compliance with 42 Ition control regulations and the CMS and Centers for d Prevention (CDC) Interest to prepare for		000	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	445509		B. WING				
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF OLD HICKORY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1250 ROBINSON ROAD OLD HICKORY, TN 37138			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Survey was conduct 12/2/2020. The fact	sed Emergency Preparedness cted by the State Agency on illity was found to be in 2 CFR §483.73 related to	EC	000			
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		TN1937	B. WING		12/02/2020			
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, STATE, ZIP CODE				
LIFE CA	LIFE CARE CENTER OF OLD HICKORY VILLA(1250 ROBINSON ROAD OLD HICKORY, TN 37138							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)	D BE	(X5) COMPLETE DATE		
N 000	was conducted by t 12/2/2020. The faci compliance under C for Nursing Homes, and has implement Control and Preven	ed Infection Control Survey he State Agency on lity was found to be in Chapter 1200-8-6, Standards infection control regulations ed the Centers for Disease tion (CDC) recommended e for COVID-19. Total census	N 000					

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE